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ABSTRACT

Training of professionals as educators in the Acquired Immune Deficiency Syndrome (AIDS) and sex education domains has been seen as part of the solution to slow down the Human Immunodeficiency Virus (HIV) transmission and eventually stop it. This study evaluated an educational guide for AIDS prevention which was distributed to youth workers (N=125) in 22 non-school agencies involved with 14- to 18-year old teenagers. Results from a questionnaire confirmed that the implementation process and the guide itself were highly satisfactory. Results indicated, however, that the only variable significantly related to utilization of the educational guide was workers' evaluation of its format and presentation. Six months after the distribution of the educational guide a training needs assessment of youth workers in AIDS domain and its prevention was conducted. Of the previous population 87 remained, and 12 new youth workers joined the study. These workers were asked to respond to a questionnaire regarding a variety of subjects such as fear of AIDS, homophobia, work-related difficulties, and stress in facing the AIDS domain. The relationship was examined between respondents' knowledge of the educational guide and results obtained in various parts of the questionnaire. No significant relationships were found between knowledge or utilization of the educational guide and knowledge of sexuality or AIDS, or attitudes toward AIDS and AIDS prevention or sexuality, or demand for additional training, or the frequency of different interventions. (LLL)

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The evaluation of educational help in Aids prevention among youth. for educators working outside the school[1].

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Communication (Round Table) presented at the Annual Meeting of the Society for the Scientific Study of Sex("Responsible sexology"), New Orleans, Nov. 1991.

In Canada[3], 5200 Aids cases were reported by August 1991(Centre fédéral sur le sida1991), and one third of these cases were located in the province of Québec[4] (second in Aids cases of the ten canadian provinces); 80% of the quebecer cases were in the Montreal region[5] (Remis 1991). For 80% of the reported canadian cases, the HIV transmission occured by the means of sexual activities (homosexual or bisexual). Therefore, sex education seems to be at stake, and Aids prevention appeared clearly within the sex education professionals and researchers' responsibilities.

As elsewhere in the world, training of different professionals as educators in the Aids and sex education domains was seen as part of the solution to slow down the HIV transmission and to eventually stop it. But the lack of well trained professionals in those domains became another aspect of the problem (Gordon & Klouda 1989; Centre Québécois de Coordination sur le sida 1991; Gaudreau 1991). So forth, the litterature on Aids prevention and sex education suggests more and more training activities and programs for educators, nurses, psycho-educators, social workers, teachers and other professionals in Aids related fields (Berthelot & Morissette 1989; Croteau & Morgan 1989; Gordon & Klouda 1989; Holder 1989; Kerr, Allensworth, Gayle, & Dalis 1989; Jacobs, Lewis & Mandel 1989; Lecorps 1989; Ostfield 1989; Tourette-Turgis 1989; Laroche & Ryan 1990; Tousignant 1990, Association de Recherche, de Communication et d'Action pour le Traitement du sida 1991; Berman 1991; Gaudreau 1991; Ministère de la Santé et des Services sociaux 1991, etc.).

Adequate professional training activities and programs need time to be prepared, organized and necessitates resources and opportunities. Although it is progressively and systematically done, the process is slow in getting all the concerned workers trained to aim at significant prevention and sex education interventions. Yet, HIV transmission is not stopped. Meanwhile, different educational tools have been provided to help Aids related professionals: pamphlets, posters, books, educational guides, videos, etc.

One of the targeted populations regarding Aids prevention is youth. Teachers were thus trained in the Aids prevention domain. But other workers deal with young people, particularly outside the school. To support out-school youth workers, the Community Health Department (here after CHD) Sacré-Coeur Hospital provided a comprehensive educational guide. This guide was developed in 1989-90 on the basis of a needs assessment of adolescents and youth workers in Aids prevention, and on the basis of scientific advices from health, education and sexology experts. The guide provides information to the educators and suggests many educational activities on various aspects of sex education and Aids prevention. The educational guide was distributed to youth workers (N=125) in 22 non-school agencies involved with 14-18 years old teenagers. These agencies included group

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3. Canadian population= approximatively 26 millions
4. Quebec population= approximatively 7 millions
5. Montral region population= approximatively 3 millions

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homes, youth shelters, community organizations and Local community services centers (LCSS). We made sure that each youth worker received a copy of the educational guide.

Following the distribution, different supportive training activities were designed to help the youth workers. In this presentation, we will insist on one part of an evaluative study of the educational guide. The purpose of that part of the study was to determine the extent to which this educational guide contributed to meet the training needs of these youth workers regarding Aids prevention. Before the description of the method used and of results, we will describe the socio-demographical and health context in which this study took place. This will allow you to point out similarities and differences between our region and others. Following this, we will summarize the process that led us to produce the guide and you will have the opportunity to look at it. Then, we will describe the methods and results of the study.

1. The context of the study

The CHD of Sacré-Coeur Hospital in Montreal, province of Québec, was founded in 1973. It covers the central northen portion of the island of Montreal. The population being served by the CHD was in 1986 of 335 859. In the Québec health structure, the main goals of CHDs are to maintain and improve physical and mental health of their populations. To reach this goal, CHDs use three major strategies: health promotion, disease prevention and public health protection. These strategies are supported by the identification and surveillance of health status of the population and through research and evaluation. These mandates come from three laws: the public health protection law, the health and safety at work law and the social and health services law. This third law mandates the CHDs in promoting health by designing and carrying out programs to improve living standards as well as the environmental, physical and mental well-being of the community.

It is in this setting that the CHD Sacré-Coeur identified the need for preventive actions in the control of STD.To meet this need, the CHD chose a mixed strategy of mobilization, information and training of youth workers (14-18). The action was splited in two phases: the creation of an educational guide (with activities in STD and Aids prevention) for youth workers and a youth workers training program. The goals of the first phase of the project was to supply, in a practical way, the youth workers with an educational tool. The educational activities in the guide aimed at lowering the incidence of STD among youngsters and of HIV transmission.

The realization of the guide took place between 1987 and 1990. In 1988, a team of professionals from the Aids and STD program of the CHD, representatives of five community clinics, of the family medicine unit and of the youth community met to set objectives for the guide and to evaluate programs and resources already available. A prerequisite to the writing of the guide was a needs assessment. In winter of 1989, we met 15 youth workers to assess their perception on their actions in STD prevention. In May and June 1989, focus groups took place with 117 teenagers ranging from 14 to 18 years old to assess their preferences in communication medias with regard to STD prevention. In spring of 1990, a questionnaire evaluating knowledge, attitudes and sexual behavior regarding STD/Aids prevention was filled by 210 teenagers in out-school settings. All this information was used to conceive the guide. During the writing period of the guide (June 1989 to April 1990), the authors, a health educator and a physician working in the Aids and STD program at the CHD, were helped by a peer committee in reviewing the content.

The educational activity guide has three general goals for youth: to acquire basic knowledge on Aids, HIV infection and STD, to improve positive attitudes regarding sexuality and Aids/STD prevention, and to acquire and improve psychomotor skills in Aids

and STD prevention. Five target behaviors were chosen for their pertinence in Aids and STD prevention: communication about sexuality, adoption of safer sex techniques, use of condoms, use of desinfected syringes and the use of health services. The underlying learning domains of the guide include the knowledge, the willingness to act, and preventive behaviors in action.

The first edition of the guide presents itself in a binder containing six paper booklets totaling 300 pages. The content was:

1) information and educational activities introducing Aids/STD prevention and descriptions of educational activities
2) for sensitization and information on Aids/STD
3) about safer sex techniques
4) about condom use
5) about use of disinfected syringes
6) and about use of health resources.

Figure 1 illustrates the implementation model of the educational guide (Laurin 1991). Consultation of experts and needs assessments that inspired the guide conception are represented at the top of the pyramid. The implementation process was conducted in two phases: spreading of the guide through the youth workers population and consolidation of the implementation. Spreading refers to the document releasing (May 1990) and distribution. First, we invited all the youth workers for a breakfast buffet. After brief speeches from the co-authors, youth workers were involved in short educational activities suggested in the guide. They received a free copy of the guide, which corresponds to one form of the distribution. Youth workers who did not attend to the meeting were personally met during the following two weeks and were given a free copy of the guide with some brief explanations, which corresponds to the second form of distribution. In figure 1, the consolidation phase refers to the recall that we have made during the three following months and to the accompanying training that youth workers received to explore the educational guide. A voluntary accompanying training session was offered, but provided on request, to help youth workers to deal with the educational guide. Recall was made by the mean of a telephone call to the authorities of the implied agencies to offer them the possibility for their youth workers to receive a three hours training session in Aids prevention related to the educational guide. We also asked them to tell their youth workers to previously read the educational guide. Nearly 70% of the agencies had the accompanying training in summer 1990. Youth workers were met individually or in small groups. A non-directive training strategy was applied. The training goals were to look at the educational foundations of the guide, to review the information on STD and Aids, to seek informations in the document, to differenciate between information for youth workers, suggested educational activities and listed resources for youth, and to provide answers to questions concerning the guide. By the end of the summer 1990, 77% of the youth workers were trained to use the educational guide on STD and Aids prevention.

The evaluative study of this educational tool took place in 1990. The objectives were to evaluate the implementation of the guide on the CHD territory and to see at what level it could contribute to the youth workers professional development in Aids prevention.

2. The first part of the evaluative study

In the first part of the study, an evaluation model was designed in accordance with the implementation model (figure 2) where youth workers were the target (Laurin 1991). Consequently, they were essentially those involved in the evaluation to answer a questionnaire designed to know their opinion on the document and on the implementation process as well as to see at what level they appropriated the educational guide and if they

had tried some educational activities with young people.The questionnaire was administered to the 125 youth-workers three months after the distribution of the educational guide.

The questionnaire was divided into six different sections. In the first part, 10 questions referred to satisfaction regarding the implementation process (location, schedule, activities, types of information from the releasing or from personalized reception, quantity of information, relevance, duration, distribution). In the second part, questions were asked about the format of the guide (separate booklets, removable booklets, size, homogeneity of presentation, and other). The third section had 10 questions about their usage of the educational guide (did they rapidly look at the content, systematically read it, and which part-information, activities-? Did they try some of the suggested activities, and which one? Do they intend to use the guide in the future?). This was followed by a serie of 17 questions on the content (do they appreciate the kind of information presented in that guide, the quantity of information? Was this new information? Was the scientific information well summarized? Does the content meet their needs? Are the listed resources useful to them? Is the quantity of suggested educational activities sufficient? Are they satisfied with the variety of the educational activities, with the quantity of these activities? Are these activities coherent with the information? Do they appreciate the kind of strategy inherent to the educational activities? Are these activities adaptable? Does this guide facilitate their work? etc.). The questions of the fourth section asked them their opinion on the accompanying training session (adequacy of goals, information they received, types of training activities, duration, usefulness of the training, etc.). The fifth section had 4 questions on their overall opinion (attractiveness of the guide, if they easily found information in the guide, if it is appropriate for youth workers, etc.). Finally, section six contains questions on socio-demographical characteristics (age, experience, etc.).

Of the 125 respondents, 54% filled the questionnaire. The majority were more than 30 years old (56%); 71% were women; 70% had a university degree; 54% were psycho-educators or animators-educators; others were nurses or coordinators of cultural or educational activities for youth. 60% of the respondents worked with 14-18 years old juvenile delinquents or emotionally disturbed adolescents.

Results confirmed that the implementation process and the guide itself were highly satisfactory. The educational guide was very interesting and the respondents found it useful, simple, well structured, and practical. For instance, results showed that their general opinion was highly positive (mean equal or higher than 4,3 /5 on different opinion items, with standard deviation from 0,5 to 0,7); 98% of the respondents expressed a highly positive overall opinion and results revealed a high degree of satisfaction (from 80% to 88% of the respondents on the different satisfaction items). Youth workers found it most adequate for their type of work with youth (mean=3,1 / 4, standard deviation = 0,66). The suggested educational activities were seen as well adapted to youth by 82% of the respondents, and to their working environment by 74% of the respondents. And 84% of the respondents expressed that the guide made them more comfortable to work in Aids and STD prevention. Some written comments showed us that, with this guide, they were more interested to work with youth in the Aids and STD prevention domain. 83% of those who participated in the training session said that this training motivated them to try some of the educational activities with adolescents.

Results indicated, however, that the only variables significatively related to utilization of the educational guide was workers' evaluation of its format and presentation (chi square=13,6; d.f.=4; p=0,01). 74% of the respondents had read systematically one or more booklets by summer 1990, and only 3% of the respondents have tried one or more of the suggested educational activities, wich is a moderate level of implementation. The main

obstacle seemed to be time: the training session occured only a few weeks before the evaluation, and the summer period did not seem suitable to organize educational activities with youth. But the second part of the evaluation, conducted during fall 1990, showed that the situation was evolving.

3. The second part of the evaluative study

Six months after the distribution of the educational guide (mid-november 1990), we conducted a training needs assessment of youth workers in Aids domain and its prevention. Of the 22 agencies, 87 of our previous population remained and 12 new youth workers joined the study. Therefore, 99 youth workers were asked to respond to a questionnaire regarding a variety of subjects such as fear of Aids (Bouton et al. 1987), homophobia (Bouton et al. 1987), work-related difficulties and stress in facing the Aids domain (O'Donnell et al. 1987; Pleck et al. 1988), attitudes towards people with Aids (Dupras et al. 1988), towards Aids prevention (Duquet 1987) and towards sexuality (Fischer 1988), knowledge of Aids and its prevention (Organisation Mondiale de la Santé 1989; King et al. 1988), and knowledge of sexuality (Michaud 1990), the number and types of Aids-related interventions performed by these participants in their working environment, their interest to follow a training course, their wishes regarding the skills and knowledge to develop in such a course, and the types of activities it should offer (Gaudreau 1991). Then we verified whether a relationship would be found between their knowledge of the educational guide and results obtained in various parts of the questionnaire.

Descriptives analysis (mean, standard deviation, frequencies analysis) were performed and followed by crosstabs and chi squares (and level of association measurements), with the use of SPSS (1990). In some cases, data were transformed into categorical data so as to enable us to produce the crosstabs and chi squares.

The response rate was 95%. Half of the respondents were 30 years old or more and 70% were women. 72% held a university degree or were studying at university level. 58% were psycho-educators or animators-educators; others were coordinators of educational activities, communitary or social workers, nurses or other. At that time, 22% of the respondents reported to have tried some of the suggested educational activities. 81% reported that they were willing to participate in an eventual training session on Aids prevention. Nearly 90% of the respondents declared that they had heard about the educational guide and 87% had it in their possession, while almost all of them (84%) have read the information section and the educational activities sections.

We asked the respondents to write their comments about the educational guide; 26 wrote some comments. Those comments were generally positive: good document, comprehensive, simple, well documented, accessible, easy to consult, useful, presenting good examples, relevance of the educational activities, interesting exercices, well adapted to youth's level of understanding, good diversity of the activities, easy to use, concrete, clear information, etc. Few negative points were expressed. They concerned workers'lack of time to apply the suggested activities, tedious reading, and one person suggested that a smaller format would have saved money.

No significant ($p<0,05$) relationships were found between knowledge or utilization of the educational guide and knowledge of sexuality, or of Aids, or attitudes towards Aids and Aids prevention or towards sexuality, or demand for additional training, or the frequency of different interventions that youth-workers reported to have done during the previous month (tables 1 to 4). These interventions were the following: to inform young people or explain something to them, to give them some documentation on the subject

matter, to have a talk with them, to listen to them, to reassure them, to refer them to somebody else, to look at posters or videos with them or show them those posters or video, or to give them condoms, to talk with them about Aids symptoms, about HIV testing or transmission, or sero-positivity, or condom use, safer sex, unsafe sex, relation between Aids and drugs use, or other subjects on Aids or sexuality. But, having the educational guide was significatively related to some of the interventions: to accompany an adolescent to a medical consultation (chi square=14,0 at p=0,00, with 1 d.f.), to speak with adolescents about local resources in the Aids domain (chi square=9,4 p=0,02 with 3 d. f.) and about syringes disinfection (chi square=20,1 p=0,00 with 3 d.f.). To have tried educational activities from the guide appeared significatively related to the number of conversations with young people about the illness progression for a person with Aids (chi square=13,1 p=0,004 with 3 d.f.), about the medication (chi square7,9 p=0,05 with 3 d.f.), and about syringes disinfection (chi square=11,6 p=0,008 with 3 d.f.). More details are presented in tables 1 to 4.

Conclusion

These results therefore tends to indicate that youth workers' training needs in Aids prevention or in preventive sex education, are not met by a single tool such as this scientifically and pedagogically designed guide. Knowledge and attitudes were not related to the use of this tool. Only a few intervention behaviors appeared related to the knowledge or the utilization of the educational guide. Other educational tools than pedagogical aides in Aids prevention are required if these workers' training needs are to be met adequately and the CHD of Sacré-Coeur Hospital is working on it.

This kind of evaluative research should be done with other youth workers, and/or with other kinds of pedagogical or educational tools as videos or books designed to help youth workers in Aids prevention. In this manner, we would be able to have more information about the way to implement educational tools, their utilization, and to assess their impact in relation with training needs in the Aids and STD prevention domain.

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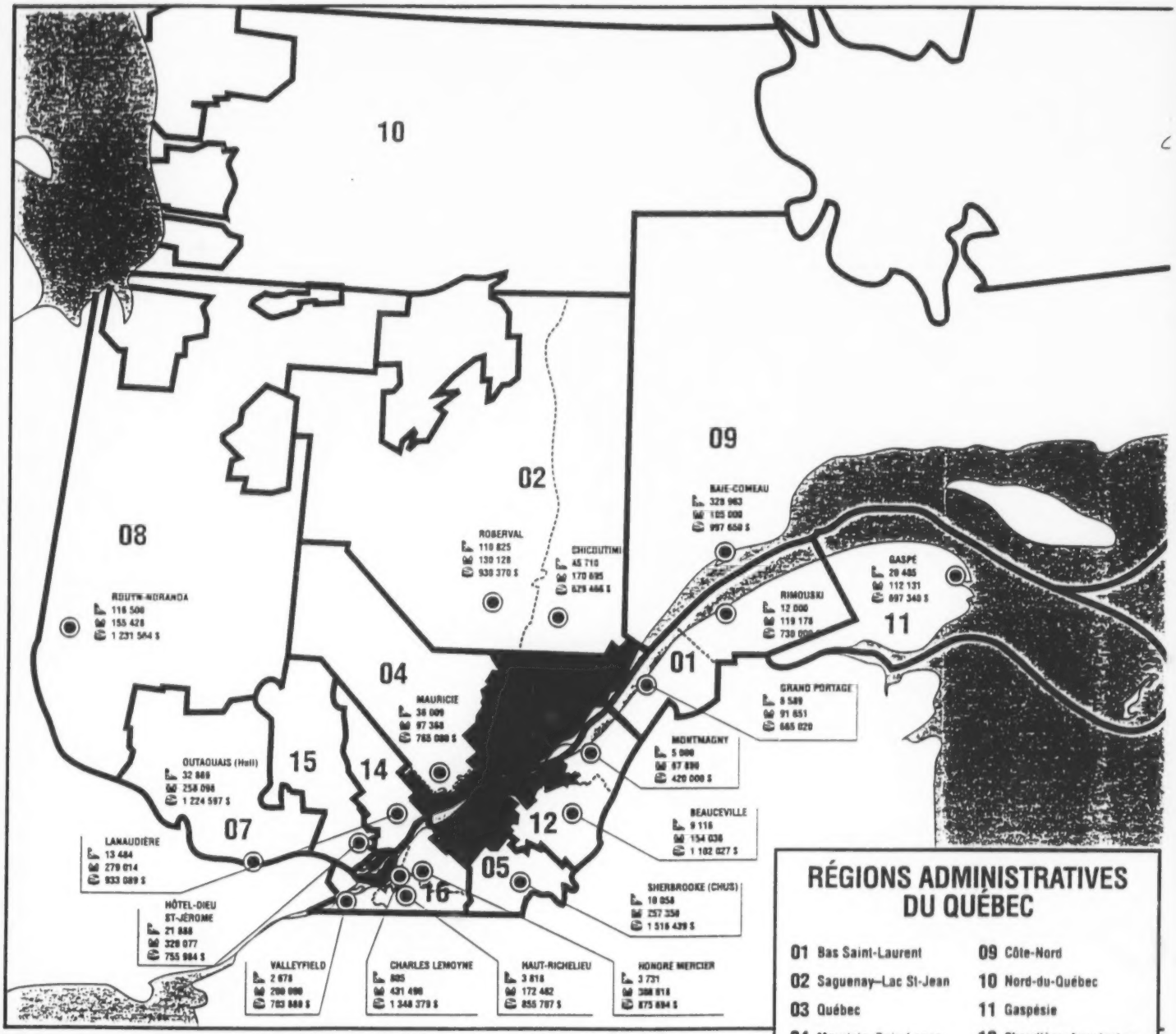
MANDATES	
1. IDENTIFY HEALTH NEEDS:	• Correctly understand and monitor the health of its population; • Identify problems and their causes; • List priorities, orient actions, evaluate the emergence of new problems and adjust choices.
2. DEVELOP PROGRAMS TO PROMOTE GOOD HEALTH AND PREVENT DISEASE:	• Design and carry out programs to improve or to change living habits and the environment, to increase the physical and mental wellbeing of the community.
3. EVALUATE HEALTH PROGRAMS:	• Conduct the necessary studies to determine if the programs have been "doing the right things" and "doing things right"; • Improve ongoing work and aim for excellence in future programs.
4. PROTECT PUBLIC HEALTH:	• Understand, monitor and control biological, chemical and physical health hazards in our environment (e.g. poisonings) and make recommendations on dealing with problem situations; • React promptly in the event of environmental disasters threatening community health; • Prevent and control epidemics.
5. PROMOTE AND PROTECT OCCUPATIONAL HEALTH:	• Identify risks which may affect health and safety (e.g. preventive reassignment); • Ensure and evaluate the services required to implement health programs in the workplace; • Promote health, ensure medical supervision and play a consulting role on subjects related to occupational health and safety.
6. STUDY AND EVALUATE THE ORGANIZATION AND OPERATION OF HEALTH CARESERVICES:	• Make recommendations to the authorities concerned regarding research to be done to ensure that services meet citizens' needs; • Ensure the quality of services offered and improve their organization and operation.

These mandates constitute the legal framework for the CHD's work, and are commonly called the "3 Ps":

. Health Promotion
. Disease Prevention
. Health Protection

These are supported by two functions:

. Understanding and monitoring the population's state of health.
. Research and evaluation.



RÉGIONS ADMINISTRATIVES DU QUÉBEC

01	Bas Saint-Laurent	09	Côte-Nord
02	Saguenay–Lac St-Jean	10	Nord-du-Québec
03	Québec	11	Gaspésie
04	Mauricie–Bois-francs	12	Chaudière–Appalaches
05	Estrie	13	Laval
06	Montréal	14	Lanaudière
07	Outaouais	15	Laurentides
08	Abitibi–Témiscamingue	16	Montérégie

LÉGENDE

- LIMITE DES RÉGIONS ADMINISTRATIVES
- LIMITE DE DÉPARTEMENT DE SANTÉ COMMUNAUTAIRE (DSC)
- LOCALISATION DU DSC
- SUPERFICIE (km^2)
- POPULATION (1986)
- BUDGET SUBVENTION MSSS

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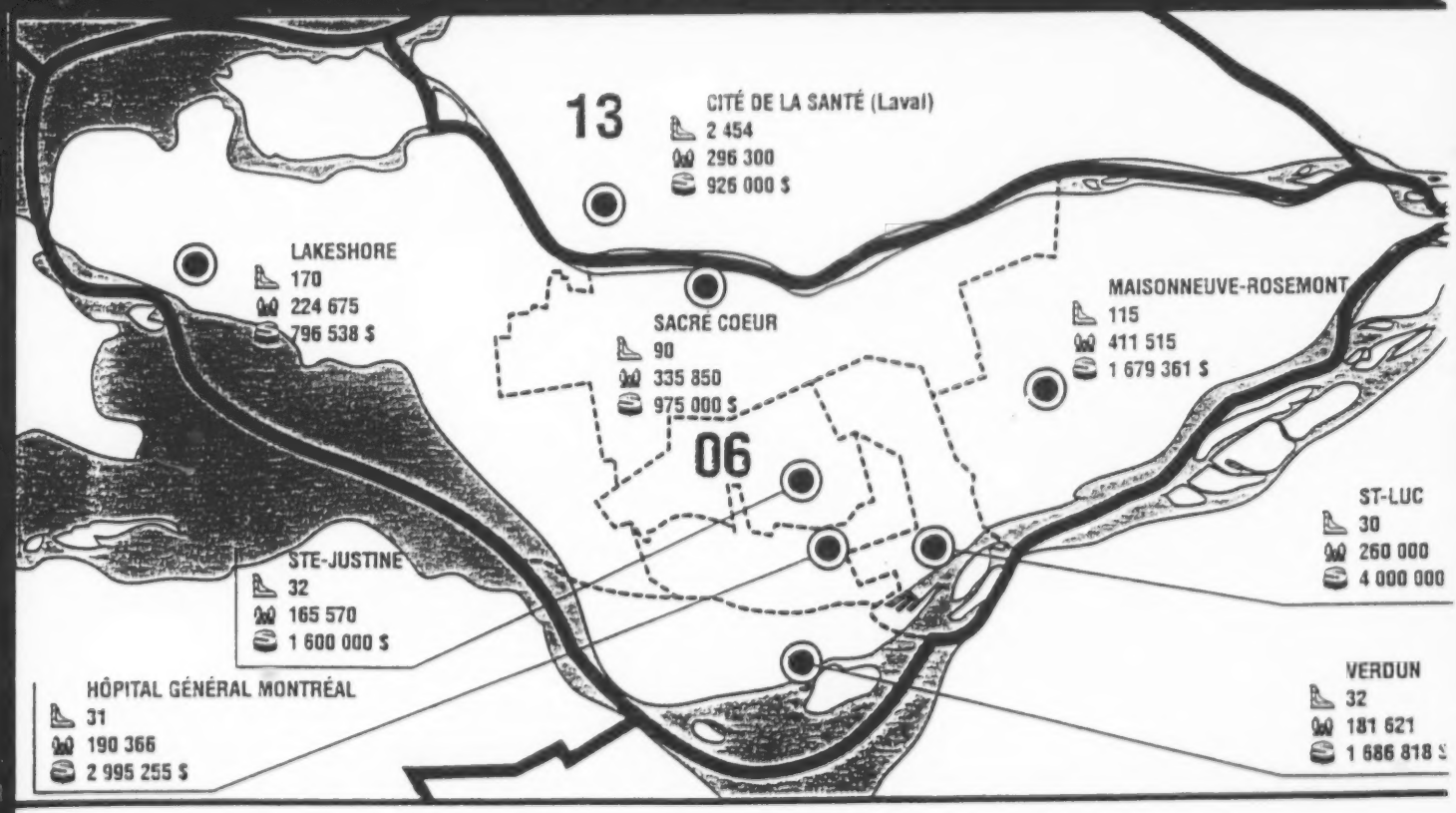
Régions de Montréal et Laval



CHIFFRES EN MAIN
DSC SACRE-COEUR, ILE-DE MONTREAL ET LE QUEBEC
AU RECENSEMENT DE 1986

EVOLUTION DE LA POPULATION	DSC SACRE-COEUR		ILE-DE-MONTREAL		LE QUEBEC	
	Nombre	%	Nombre	%	Nombre	%
. Population en 1981	338 227	-	1 760 122	-	6 438 403	-
. Population en 1986	335 859	100,0	1 752 582	100.0	6 532 461	100,0
. Taux de variation entre 1981 et 1986	-	-0,7	-	-0,4	-	+1,5
POPULATION SELON L'AGE						
. Les moins de 5 ans	17 627	5,3	93 760	5,4	431 910	6,6
. Les moins de 15 ans	53 923	16,0	276 665	15,8	1 341 040	20,5
. Les 15-19 ans	23 920	7,1				
. Les 20-24 ans	34 130	10,2				
. Les 65 ans et plus	42 497	12,7	224 350	12,8	650 640	10,0
. Les 75 ans et plus	16 189	4,8	88 195	5,0	243 125	3,7
POPULATION DE 15 ANS ET PLUS SELON L'ETAT MATRIMONIAL						
. Population de 15 ans et plus:	281 886	100,0	1 475 920	100,0	5 191 415	100,0
- Veufs - veuves	21 547	7,6	112 005	7,6	317 795	6,1
- Divorcé(e)s	13 614	4,8	74 695	5,1	198 910	3,8
POPULATION SELON LA LANGUE MATERNELLE						
. Réponse unique:	309 496	92,1	1 631 115	93,1	6 290 680	96,3
- Français	209 019	62,2	1 008 440	57,5	5 316 925	81,4
- Anglais	30 757	9,2	332 015	18,9	580 025	8,9
- Langue non officielle	69 636	20,7	290 660	16,6	393 725	6,0
. Réponses multiples	26 396	7,9	121 470	6,9	241 780	3,7
LOGEMENTS						
. Logements privés occupés:	132 932	100,0	722 460	100,0	2 357 105	100,0
- Logements loués	88 648	66,7	489 520	67,8	1 062 570	45,1
- Maisons individuelles non attenantes	12 017	9,0	84 965	11,8	1 032 605	43,8
- Immeubles de 5 étages et plus	16 050	12,1	83 190	11,5	116 110	4,9

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CHIFFRES EN MAIN (SUITE)
DSC SACRE-COEUR, ILE-DE MONTREAL ET LE QUEBEC
AU RECENSEMENT DE 1986

LES MENAGES	DSC SACRE-COEUR		ILE-DE-MONTREAL		LE QUEBEC	
	Nombre	%	Nombre	%	Nombre	%
. Ménages privés occupés	132 956	100,0	722 460	100,0	2 357 105	100,0
- composés d'une personne	36 790	27,7	224 680	31,1	510 550	21,7
- non familiaux	43 733	32,9	273 125	37,8	621 470	26,4
- familiaux (1 ou 2 familles)	89 228	67,1	449 330	62,2	1 735 640	73,6
. Personnes dans les:						
- ménages privés	328 605	97,8	1 710 310	97,6	6 391 435	97,8
- ménages collectifs	7 293	2,2	42 270	2,4	141 025	2,2
. Personnes de 65 ans et plus dans les:						
- ménages privés	38 186	89,9	201 515	89,8	579 025	89,0
- ménages collectifs	4 311	10,1	22 835	10,2	71 615	11,0
. Nombre moyen de personnes par ménage privé	2,5		2,4		2,8	
LES FAMILLES						
. Familles de recensement dans les ménages privés	90 472	100,0	454 730	100,0	1 751 500	100,0
. Familles époux-épouses:						
- avec ou sans enfant(s)	73 387	81,1	371 610	81,7	1 498 690	85,6
- avec enfant(s) seulement	42 538	46,6	208 545	45,9	961 255	54,9
. Familles monoparentales*	17 039	28,8	83 115	28,5	252 805	20,8
. Nombre moyen de personnes par famille de recensement	..		2,9		2,8	
LES ENFANTS						
. Enfants dans les familles de recensement	103 042	100.0	504 920	100,0	2 222 085	100,0
. Nombre moyen d'enfants par famille de recensement	..		1,1		1,3	

Source: . Statistique Canada, recensement de 1986. Les données ont ensuite été pondérées par le Comité régional de connaissance surveillance de l'état de santé de la population (région 6A) afin de tenir compte des limites géographiques du DSC Sacré-Coeur

. Statistique Canada, catalogue 94-109

* Calculé à partir des familles avec enfant(s) seulement

DSC SACRE-COEUR

ETHNIE ET IMMIGRATION	Nombre	%
.Population hors institution	331 415	100,0
.Origine française	191 325	57,7
.Immigrants	80 655	24,3
.Ne parle pas français	34 910	10,5
.Citoyens non canadiens	18 425	5,6
.Nouveaux immigrants	7 645	----

MOBILITE		
.Population de 5 ans et +	313 690	100,0
.Ayant déménagé	146 220	46,6
.Dans la région	119 533	38,1
.D'une autre région	14 132	4,5

LOGEMENTS		
.Nouveaux logements	8 655	----
.Loyer brut moyen	458 $	----
.Valeur moyenne de propriété	101 212 $	----
.Loyer ≥ 30% du revenu	13 580	29,3

SCOLARITE		
.Population de 15 et +	277 575	100,0
.Pas de diplôme	119 480	43,0
.Diplôme universitaire	25 640	9,2

ACTIVITE ET CHOMAGE	NOMBRE	%
.Population active - hommes	94 505	74,1
.Population active - femmes	79 665	53,1
.Chômeurs	10 510	11,1
.Chômeuses	10 450	13,1
.Familles 0 membre actif	15 845	17,5

SECTEUR D'ACTIVITE/EMPLOI		
.Population active expérimentée	167 710	100,0
.Secteur autres services	52 150	31,1
.Manufactures	42 935	25,6
.Commerce	33 025	19,7
.Groupe C* - hommes	37 285	40,8
.Groupe B* - femmes	41 555	54,5

REVENUS ET PAUVRETE		
.Revenu moyen du ménage	29 730 $	----
.Personnes à faible revenu	84 255	25,7
.Personnes très pauvres	40 800	12,4
.Familles à faible revenu	20 655	22,2
.Personnes seules à faible revenu	20 415	44,7

* Groupe C: travailleurs de production, transport, construction, etc.
Groupe B: employés de bureau, vente et services

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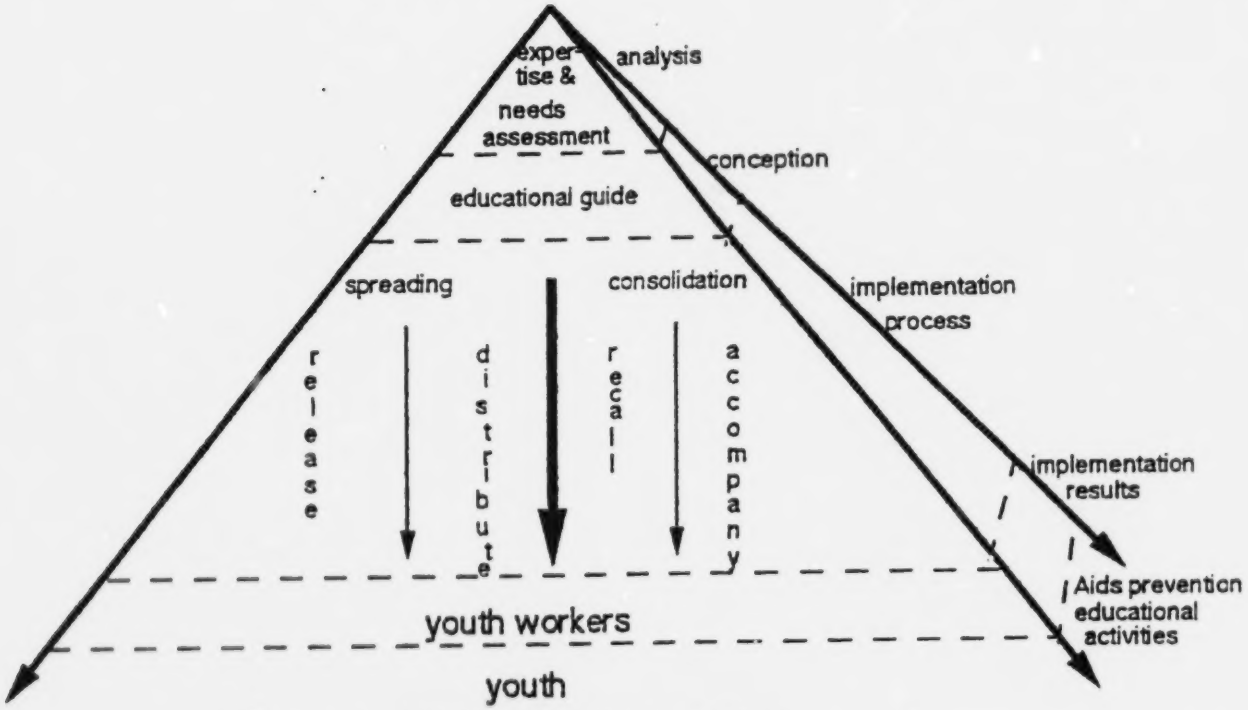

Figure 1: Model of implementation

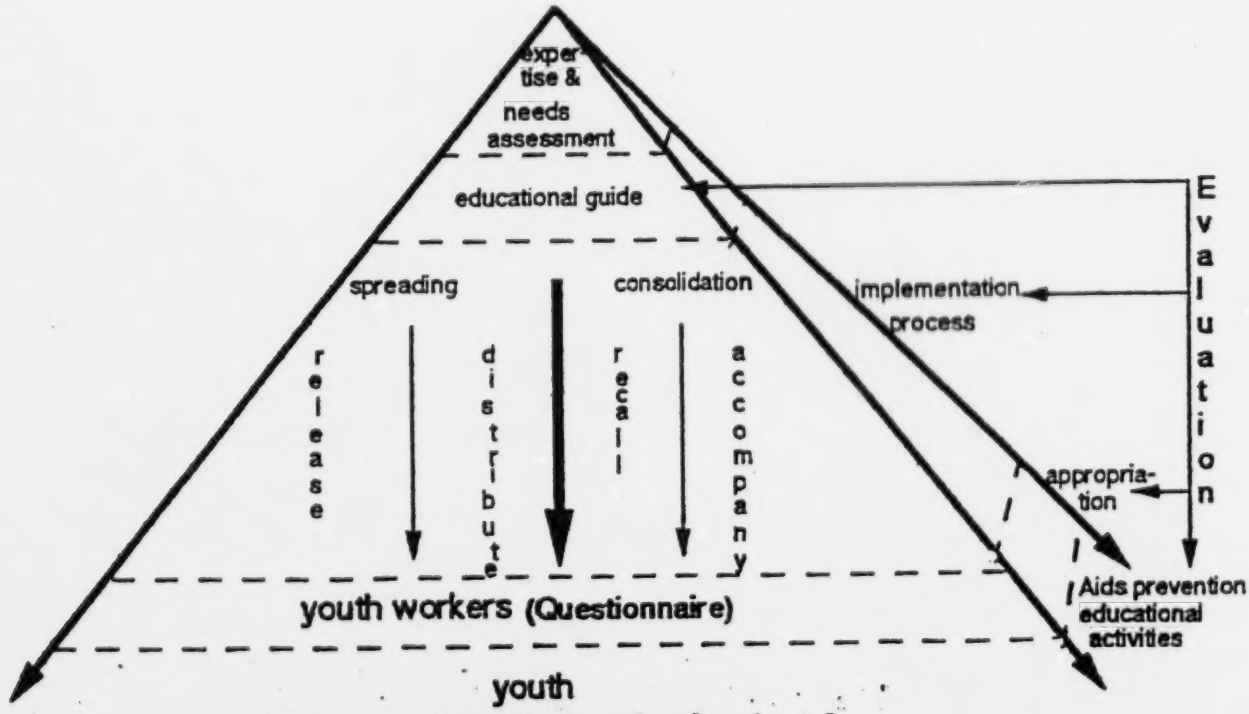

Figure 2 : Model of evaluation

Table 1: General results: Knowledge and attitudes (second part of evaluation)

Test	N	Mean	Maximum	Standard deviation
1) Attitudes[1]				
a) Aids phobia (Aidsphobic tends to 0)	94	33,0 (59%)	56	6,5
b) Attitude towards prevention (positive tends to 95)	94	76,8 (81%)	95	5,4
c) Stress facing Aids domain (stressed tends to 20)	94	5,9 (30%)	20	1,3
d) Attitude towards people with Aids (positive tends to 10)	94	9,3 (93%)	10	1,0
e) Homophobia (homophobic tends to 0)	94	23,3 (83%)	28	4,7
f) Attitude towards sexuality (negative tends to 7)	94	2,9 (84%)	1	1,0
2) Knowledge				
a) HIV transmission (OMS 1989)	94	89,0	100	8,1
b) Aids general knowledge I (Dupras et al. 1987)	94	88,6	100	8,3
c) Aids general knowledge II (King et al. 1988)	85	78,1	100	12,4
d) Sexuality general knowledge (Michaud 1990- S.K.A.T.)	55	68,8	100	9,6
- Overall knowledge	84	74,2	100	7,1

Table 2: Knowledge and use of the educational guide

Type of knowledge	% of respondents (N= 93)
- To know the educational guide	90
- To have a copy of the educational guide	97
- To read the content (information and activities)	95
- To have tried some of the suggested activities	22

1. Reliability of the attitude scales: Cronbach alpha=from 0,7 to 0,9

Table 3: Frequencies (%) : Interventions during last month (second part of evaluation)

Types of activities in Aids prevention	n times by month by % of respondents				N
	never	1-3	6-10	more than 10	
- To, inform, to explain	16	48	37	0	82
- To give documentation	43	33	24	0	82
- To have a conversation	14	43	43	0	79
- To listen	30	34	36	0	80
- To reassure	54	25	20	0	79
- To refer to somebody else	68	27	5	0	79
- To look at film, posters... with young people, or show films, posters,etc.	63	31	6	0	81
- To accompany young people for medical consultation*	93	7	0	0	81
- To give objects (e.g. condom)	63	21	17	0	83

* Related to "having the educational guide" :chi square= 14,0 p=0,00, 1 d.f.

Table 4: Frequencies (%) of respondents by number of young people to whom they gave information on Aids during the last month (second part of the evaluation)

Topics	n of adolescents by month, by % of respondents				N
	none	1-5	6-10	more than 10	
- Aids symptoms	63	19	10	8	93
- HIV testing	66	25	5	4	93
- Progression of the illness of people with Aids***	81	10	3	7	93
- Medication for Aids treatment**	89	5	2	3	93
- Resources in the Aids domain*	72	17	7	4	93
- HIV transmission	32	40	18	10	93
- Sero-positivity	61	22	12	5	93
- Syringes disinfection****	73	17	7	3	93
- Condom	24	45	17	14	93
- Safer sex	43	34	15	8	93
- Unsafe sex	48	28	15	9	93
- Drugs, medication and sex	71	17	7	5	93
- Other topics about Aids	85	5	5	4	93
- Other topics about sexuality	48	25	15	12	93

* Related to "having the educational guide": chi square=9,4 p=0,02 with 3 d.f.
**Related to "having tried the suggested educational activities": chi square=7,9 p=0,05, 3 d.f.
***Related to "having the educational guide": chi square= 13,1 p= 0,004 3 d.f.
****Related to "having the educational guide": chi square= 20,1 p=0,00 3 d.f. , and related to "having tried suggested educational activities": chi square=11,6 p=0,008 3 d.f.